AUTHORIZATION TO RELEASE HEALTH INFORMATION

2015 TULALIP TRIBES OF WASHINGTON WELLNESS PROGRAM

Good news! As a full-time employee covered on the Tulalip Tribes of Washington health plan, you are eligible to participate in the Tulalip Tribes of Washington wellness initiative through Cooper Wellness. Simply schedule an appointment with your doctor, bring a copy of the affidavit and authorization form (page 2 and 3 of this packet), undergo a preventive health screening, and ask that your results be sent to Cooper Wellness. The preventive exam will include measuring your height, weight, waist circumference, blood pressure, cholesterol and glucose levels. Upon completion of this process, you will qualify to receive an incentive. Members enrolled on our Bronze plan will receive a $50 gift card to Tulalip Resort Casino. Members enrolled on our Gold or Platinum health plans will receive a premium incentive of $50 per month in our 2015-2016 plan year.

Always know that your personal information will remain just that—personal. Tulalip Tribes of Washington *will never* see your individual screening results. Your results are kept safe in Cooper's secure database. Screening results become part of aggregate data report that will help Tulalip Tribes of Washington enhance your wellness program.

Ready to get a clearer picture of your health? Just follow these easy steps to collect your incentive!

1. **Schedule an appointment** with your primary care physician (PCP) between 11/1/14 – 9/1/15. If you do not have a PCP or are unsatisfied with your current one, refer to the AccessHMA.com website and search for a physician. The most affordable physicians will be those who are in network with your health plan.

2. **Complete BOTH pages** of the attached form (Page 2 Authorization to Release Health Information and Page 3 Biometric Screening Affidavit), and bring them to your appointment and present them to the doctor or medical staff. *Note: If you had your measurements taken recently (between 11/1/14 – 9/1/15), you may send both pages to your doctor's office to fill in, and return to Cooper.*

3. **Undergo appropriate tests** to collect required health measures.

4. **Ask the office staff to: Complete the remaining sections** of the Biometric Screening Affidavit (page 3) when they receive your lab results **and submit** BOTH Page 2 and Page 3 no later than 9/15/15. *Note: Forms submitted directly from a participant will not be accepted.*

   IMPORTANT! Before you leave your appointment, obtain a copy of Page 2 Authorization to Release Health Information from the office staff for your own records.

5. **Get confirmation** from your Tulalip Tribes of Washington HR representative within 7 business days from when your form has been received. *It is your responsibility to follow up with the doctor's office to ensure the form is submitted in a timely manner.* If incomplete results are submitted, your HR representative will notify you so you can obtain missing values from your medical provider.

6. **Collect your incentive—have a clearer picture of your health, and congratulate yourself on a job well done!** Incentives will be distributed by Tulalip Tribes of Washington.

NOTE: If you have printed documentation of your biometric data—for example, from an online medical records portal or a lab report—you may submit both pages of this form along with the formal, printed documentation from the medical provider. No affidavits submitted by a participant without documentation will be accepted.

Any expenses not covered by insurance (for example, cost of filling out the form) are the employee's responsibility.

For questions or more information about the affidavit, please contact the Cooper Wellness support team at usidata@cooperaerobics.com or 972.560.5467. For all other inquiries (i.e. insurance coverage, etc.) please contact your company Benefits Department.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

2015 TULALIP TRIBES OF WASHINGTON WELLNESS PROGRAM

Participant Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____

Email: _____ Phone Number: _____

I, or my authorized representative, request that health information related to my participation in the Tulalip Tribes of Washington wellness program be released as set forth on this form. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. **Cooper Wellness Strategies will not disclose my health information to Tulalip Tribes of Washington or any other party except as allowed in this authorization or as otherwise permitted or required by HIPAA.**
2. I have the right to revoke this authorization at any time by writing to the entity listed in Item 7 below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
4. Information disclosed under this authorization might be redisclosed by the recipient (i.e. the secondary recipients), and this redisclosure may no longer be protected by federal or state law.
5. Health information to be released: **All information included in this authorization and the attached Biometric Screening Affidavit (see page 3).**
6. Class of persons authorized to release this information: **Any physician, health care provider, facility or laboratory to which I have provided this authorization with the attached Biometric Screening Affidavit.**
7. Name and address of the person or entity to which this information may be released: **Cooper Wellness Strategies, 12200 Preston Road, Dallas, Texas 75230, Fax: 1.855.897.9900.**
8. Reason for release of information: **In fulfillment of the Tulalip Tribes of Washington wellness program in which I am a participant.**
9. In fulfillment of the Tulalip Tribes of Washington wellness program, I further authorize Cooper Wellness Strategies to: **(i) provide a duplicate of my summary wellness report(s) based on the aforementioned health information to my primary care physician/health care provider (and specialty physician, if requested); (ii) provide participation reports to Tulalip Tribes of Washington and if requested by Tulalip Tribes of Washington to its insurance broker, USI Insurance, LLC or its affiliate, if applicable ("USI") to notify those parties if and when I have participated in an applicable biometric screening; (iii) provide my tobacco affidavit(s) and dental visit affidavit(s) (if applicable) to Tulalip Tribes of Washington and/if requested by Tulalip Tribes of Washington to USI; (iv) provide a data export to {Third Party}, and (vi) provide de-identified aggregate health population reports to Tulalip Tribes of Washington and if requested by Tulalip Tribes of Washington, to USI.**
10. This authorization will expire on: **The date I revoke this authorization in writing to Cooper Wellness Strategies.**

All items on this authorization have been read and my questions about this authorization have been answered. I will be provided a copy of the signed authorization.

_____ Date: _____/_____/_____

Signature of Participant or Representative Authorized by Law

_____ _____

If Not the Participant, Printed Name of Representative Signing Form Relationship/Authority to Sign

Provider must provide a copy of this completed authorization to the participant. A copy of this authorization will have the same force and effect as an original.

Remit to Cooper Wellness, Attn: Alexandra Cherry, 12200 Preston Road, Dallas, TX 75230 or fax to 1.855.897.9900. For questions about this form, call 972.560.5467 or email usidata@cooperaerobics.com. Please contact your Benefits Department with all other inquiries (insurance coverage, etc.).

BIOMETRIC SCREENING AFFIDAVIT

2015 TULALIP TRIBES OF WASHINGTON WELLNESS PROGRAM

Measurement Period: 11/1/14 – 9/1/15

Use this form to submit health measurements from your doctor's office in fulfillment of the Tulalip Tribes of Washington wellness program. Any expenses not covered by insurance (for example, cost of filling out the form) are the employee's responsibility.

TO BE COMPLETED BY PARTICIPANT (Please print legibly)

Participant Name: _____ Date of Birth: _____/_____/_____

Email: _____ Phone Number: _____

Employee ID:_____ Circle Applicable: Employee

Do you currently use tobacco products? Circle One: Y N

Do you exercise 150 minutes per week? (Example: 30 minutes 5 days per week) Circle One: Y N

TO BE COMPLETED & SUBMITTED BY MEDICAL PROVIDER (Please print legibly)

Fill in **ALL** of the following medical data **measured between the dates of 11/1/14 – 9/1/15.**
Missing or late information will affect the participant's participation status in his/her corporate wellness program.

Physical Data:		**Lipid & Glucose:**		**Existing Conditions:**	
Height:	_____ inches	Total Cholesterol:	_____	Heart Disease (Y/N)	_____
Weight:	_____ pounds	Triglycerides:	_____	(MI, CABG, PTCA)	
Waist:	_____ inches	HDL:	_____	Diabetes: (Y/N)	_____
Blood Pressure:	_____ / _____	LDL:	_____	Prediabetes: (Y/N)	_____
		Glucose:	_____		

I have personally reviewed the above records. I certify that these records are accurate concerning the above-named participant during the above-mentioned period, and that these records were prepared by me or members of the staff of this facility. I understand this is a preventive visit and should be coded as such.

_____ _____ _____/_____/_____

Signature of Physician or Medical Provider Medical License # Date

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

IMPORTANT: *BOTH PAGE 2 AND PAGE 3* of this completed form must be returned *directly from the medical provider* no later than 9/15/15.

Remit to Cooper Wellness, Attn: Alexandra Cherry, 12200 Preston Road, Dallas, TX 75230 or fax to 1.855.897.9900. For questions, call 972.560.5467 or email usidata@cooperaerobics.com. Please contact your Benefits Department with all other inquiries (insurance coverage, etc.).